

#### Post-Deployment Management of Combat-Related Distress Reactions and Disorders

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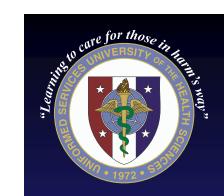
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# Objectives

- Overview of "Differential Diagnosis" in the aftermath of Traumatic Exposure
- Comments on Intervention
  - Recovery environment
  - Psychosocial and Pharmacological Therapy
- Case Vignette





#### Resources

- www.usuhs.mil/CSTS
- Iraq War Clinician Guide, 2<sup>nd</sup> Edition; www.ncptsd.va.gov/war/guide
- Benedek DB and Ursano RJ, "Military and Disaster Psychiatry," in Saddock BJ and Saddock VA, eds, Kaplan & Saddock's Comprehensive Textbook of Psychiatry, 8<sup>th</sup> ed., Lippincott, Williams, & Wilkins, 2005.





### Traumatic Stress Response

- Phase I--Immediate Response
  - strong emotions, disbelief, numbness, fear, confusion
  - Signs/Symptoms of Anxiety and Autonomic
     Arousal are a predictable response
  - Result of release of stress hormones/catecholamines





#### Traumatic Stress Response

- Phase II--Delayed Response (after one week)
  - Intrusive Recollections
  - Persistent autonomic arousal (startle, hypervigilance, insomnia, nightmares)
  - Multiple Somatic Symptoms (dizziness, headache, fatigue, nausea)
  - Anger/Irritability, Grief/Mourning, Apathy/Withdrawal





### Traumatic Stress Response

- Phase III--Chronic (months to years)
  - disappointment/resentment
  - continued intrusive/arousal symptoms for some
  - persistent sadness/resentment for others
  - avoidance of triggers/reminders
  - Re-focus on new challenges/rebuilding of lives for majority



# Differential Diagnosis: Phase II

- Continued Autonomic Symptoms
  - PTSD
  - Substance Abuse
  - Somatization Disorder
- Persistent Anger/Irritability/Depression
  - Major Depressive Disorder, Other Depressive Dx
- Bereavement/Complicated Grief





- Autonomic Symptoms
  - PTSD

ing to care for those in a

- secondary effects of exposure chem/bio?
- Mood Disturbance
  - Recurrent Major Depression
  - Dysthymic Disorder
  - Substance Abuse/Dependence





#### Diagnostic Distinctions

- With anxiety, duration, degree of impairment clarify "normal" v. acute stress disorder v. PTSD
- With mood duration, degree, and identified loss clarify MDD v. Dysthymic Disorder v.Grief Reaction
- Caveat: "Distress" need not have fit into a DSM-IV diagnostic category





#### Treatment Considerations

- Pre-morbid history (function/presence of mental disorder) important considerations for treatment/prognosis
- History (personality/substance use) equally important in ruling in/out or predicting potential contributions of alcohol/drugs to observed symptoms (somatic, mood, or anxiety)





#### Other Factors in Assessment

Stressors Not Directly Related To Combat

Recovery Environment

Comorbidity and/or Sub-threshold symptoms





### Summary

- Individuals may present with a variety of symptoms/syndromes across a timeline after combat exposure; PTSD is one consideration
- Initial symptoms may reflect physical injury/exposure, do not necessarily predict long-term morbidity (even if symptoms are severe)
- Information/risk communication and triage are initial considerations



# Summary (cont.)

- Beyond direct exposure:
  - Anxiety Disorders (PTSD)
  - Mood Disorders
  - Somatization Disorders
  - Substance Use Disorders
  - Grief Reactions
  - Distress
- Duration/degree of impairment clarify diagnosis/prognosis and direct treatment





# Management Considerations

Importance of the Recovery Environment

Treatment of Specific Disorders

Intervention beyond treatment of Disorder





#### Range of Mental Health in Disaster

Mental Health & Illness

Distress Responses Human
Behavior in
High Stress
Environments

- Change in Safety
- Sleep Disturbance
- Change in Travel

- Resilience
- PTSD
- ASD
- Depression

- Evacuation
- Smoking
- Alcohol
- Over dedicate



#### Female US Reserve E-6

- Short of breath, unable to pump gas
- Re-deployed due to reactive airway disease in theater
- No significant battle exposures
- Only woman in Gulf fuel supply unit
- Tent set on fire with her inside
- Rescued, but no significant action taken





### Symptoms and problems

- Poor sleep/nightmares
- "Not as helpful" at her civilian workplace
- Feels isolated
- Angry at self for increased tobacco use even-she knows its not good for asthma; inhalers make her more nervous . . .
- Limited contact with her parents; spouse says "We're both lucky you are home & safe."



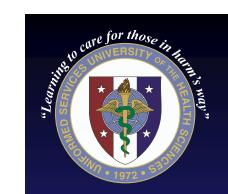
# Enhancing the Recovery Environment

#### **Recovery Is promoted by:**

- Finding benefit
- Sense of relationship with the divine
- Trauma exposure-type treatment
- Other forms of treatment (supportive, stress inoculation, CBT, etc)
- Disclosure / Social support
- Perception that the social milieu accepts one's reactions and welcomes disclosure
- Seeing ourselves as heroes/survivors
- Positive emotions

» Watson, P. NCPTSD, 2005





#### Treatment of Disorders

- Psychotherapy
  - CBT and Exposure-based therapies
  - EMDR
- Pharmacotherapy
  - SSRIs
  - Other medications
- Evidence Basis
- Practice Guidelines (APA, VA/DoD)





# APA Practice Guidelines: Initial Assessment

- Comprehensive assessment should only be made in a safe environment, usually several days to weeks following the event.
- More acutely, supportive measures to provide information, relieve anxiety, ensure safety, and attend to physical problems and routine needs are appropriate.
- There is no evidence supporting the use of wide scale individual or group debriefing techniques for the prevention of PTSD.



### Specific Information for Military

- Reason for joining
- Nature of duties and length of service
- Disciplinary actions and awards
- Frequency and effects of separation from family
- Location of events, seeing atrocities, death or injury of children or friends
- Sense of guilt with regard to actions or inaction





#### Selection of Treatments

- What does the patient see as primary problem(s), what settings, and which are most troubling
- What are the short and long term goals
  - Reduction in symptoms
  - Adaptive coping
  - Reduce restrictions of daily living / risk behaviors
  - Enhance decision making skills
  - Improve interpersonal relationships
  - Examine personal beliefs, expectations, constructs re: future, risks of life, and sense of safety





#### Management of Co-morbid Disorders

- Mood and anxiety disorders and substance misuse contribute to the severity of symptoms and course of the disorder
- Treatment of co-morbid disorders should be initiated in parallel with treatment of PTSD





#### Psychopharmacologic Treatment

- SSRIs are first line pharmacologic treatment:
  - Ameliorate all three symptom clusters
  - Effective for co-morbid disorders (mood and anxiety – possibly substance use)
  - May reduce irritability and aggressive behaviors that complicate management
  - Relatively few side effects
  - Only medications shown to benefit in well designed prospective trials





#### Adjunctive Treatments

- Second generation antipsychotic medications may have a role if there is evidence of misperception or paranoia and in low dose for sleep or agitation
- Benzodiazepines should be avoided (or at least considered carefully) because they may interfere with cognitive processing
- Beta blockers and alpha agonists may play some role
- Recently published studies of prazocin support its use; this appears particularly effective in reducing intrusive symptoms (nightmares).\*\*



# Psychotherapy for PTSD

- Cognitive Behavior Therapy (CBT):
  - Corrects irrational beliefs & thoughts
  - Promotes rational behavioral changes
- Other Exposure-based therapies:
  - Helps confront stimuli associated with trauma
  - Identifies & neutralizes behavioral cues
  - Virtual reality may provide most effective exposure mechanism
    - Appears useful in Vietnam vets and WTC survivors though not yet proven in controlled studies

